HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use and attach a copy of your insurance policy, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions and information collection and access are on the reverse. If you have any questions about completing this form or require Spanish translation, call toll-free 1-800-952-5294 (8:00 a.m. to 5:00 p.m.).

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS/HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDI-CAL ELIGIBILITY; HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDI-CAL ELIGIBILITY.

Case name / Case address	FOR COUNTY USE ONLY	STATE USE ONLY	
	Worker number	Verified by	
	Date	Date	Initials
	Worker telephone number ( )	Date	Initials
❒ Initial Intake ❒ Redetermination ❒ HIPP	***Optional*** District number	Scope	CC number

SECTION I: Beneficiary Information ***LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY***

OHC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	14-DIGIT MEDI-CAL NUMBER: Co. Code	Aid Code	Case Number	FBU	Pers. No.
		— —							
		— —							
		— —							
		— —							
		— —							
		— —							

SECTION II: Health Insurance Information

1. What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
   Name: _____
   Address: _____
   City, State, ZIP: _____
2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) ❒ Yes ❒ No
3. Where do you send your claims?
   Name: _____
   Address: _____
   City, State, ZIP: _____
4. What is the full name, address, phone number, and SSA number of individual, employee, union member, or person to whom the insurance policy was issued?
   Name: _____ Social security number: _____
   Address: _____ Telephone number: ( ) _____
   City, State, ZIP: _____ Absent parent? ❒ Yes ❒ No
5. What is the policy number? _____
6. What are/were the dates of your policy? Beginning date: _____ Ending date (if applicable): _____
   ❒ Medical coverage available through employer, but has not been applied for.
7. Premium amount: $_____ ❒ Monthly ❒ Quarterly ❒ Yearly
   How are premiums paid? ❒ By Insured to insurance carrier ❒ By employer ❒ By payroll deduction
8. Give name, address, and telephone number of union, employer, group, organization, or school.
   Name: _____ Local or group number: _____
   Address: _____ Telephone number: ( ) _____
   City, State, ZIP: _____
9. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? ❒ Yes ❒ No
   If yes, please specify the illness: _____
10. Does your health insurance provide or pay for: (Check *all* that apply.)
    ❒ Hospital outpatient (i.e., lab work/ physical therapy) ❒ Prescription drugs ❒ Long-term care/nursing home
    ❒ Hospital stays ❒ Dental care ❒ Only specific illness (i.e., cancer)
    ❒ Doctor visits ❒ Vision care Type of illness: _____
11. Is the policy a Medicare Supplement? ❒ Yes ❒ No

Remarks:

"By signing this document, I hereby authorize the California Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, to be used in determining whether the Department will pay my private health insurance premium."

Signature of applicant	Home telephone	Work telephone	Date
	( )	( )	

RETURN COMPLETED FORM TO: THIRD PARTY LIABILITY BRANCH, MS 4719, P.O. BOX 997422, SACRAMENTO, CA 95899-7422

Original—State ***Copy—County File*** ***Copy—Beneficiary***

INSTRUCTIONS

Section I: Beneficiary Information

List the names (first, middle, last) of all persons on Medi-Cal and covered by the health insurance policy. Also, list each person's Social Security number, sex, and date of birth. If any person listed is expecting a child, on the last available line, put "unborn" in the name section and the expected date of arrival in the date of birth section. Enter Medi-Cal numbers, if known; otherwise, your eligibility worker will complete that section.

Section II: Health Insurance Information

Item No. 1: Enter the full name and mailing address of your insurance company. (Include street address and/or P.O. Box, city, state, and ZIP.) DO NOT USE ABBREVIATIONS!

Item No. 2: Check the appropriate box if you have to obtain medical services from a specific facility or a group of providers (Prepaid Health Plans [PHP], Health Maintenance Organizations [HMO], Preferred Providers Organizations [PPO]).

Item No. 3: Enter the complete name and mailing address where your health insurance claims are sent. Only complete if different from the answer to Item No.1.

Item No. 4: Enter the full name, mailing address, telephone number, and social security number of the individual, employee, union member, retired employee, or person to whom the insurance policy is or was issued (insured). Check the appropriate box for an absent parent.

Item No. 5: Enter the number the insurance company needs to identify the policy. This number is sometimes called: subscriber, certificate, account, employee, group, and local number.

Item No. 6: Enter the date (month/day/year) the insurance policy began and date terminated. If known, enter the policy lapse dates, and check the box if medical coverage is available through an employer which has not been applied for.

Item No. 7: Enter the premium amount; check the box if they are paid per month, quarter, or year, and how the premiums are paid. Check appropriate box(es).

Item No. 8: If the policy is purchased through a union, employer, group, organization, or school, enter the name, address, telephone number, local or group number, if known.

Item No. 9: Check the box "YES" or "NO" if any covered beneficiary has an acute or chronic pre-existing illness that requires him or her to see a physician. Specify the illness.

Item No. 10: Read and check items which apply to your insurance coverage.

Item No. 11: Read and check yes or no.

Signature Section: Please sign the form and give your home and/or work telephone number. If you do not have a telephone, please put a message number in the home telephone box. Also, enter the date when you completed this form.

IMPORTANT: As a condition of eligibility, all Medi-Cal beneficiaries shall assign rights to medical insurance, support, or other third-party payments to the Medi-Cal program and shall cooperate with the California Department of Health Services in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medi-Cal program. Assignment of medical rights allows the California Department of Health Services to recover funds from health insurance companies or funds when the Medi-Cal program pays for medical services which should have been billed to such other health insurance coverage. Please note that in order to comply with the Federal Privacy Act (42 USC Section 552a), your social security number and any information you provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2, any submitted information is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes.

INFORMATION COLLECTION AND ACCESS

Sections 50761 and 50763 of Title 22, California Code of Regulations (CCR), requires recipients to report other health coverage to which they are entitled.

The information requested is necessary to make possible the recovery of health insurance or other contractual or legal entitlements as provided in Welfare and Institutions Code, Sections 10020 through 10025, 14024, 14103, and 14124.70, from persons liable thereunder.

Information concerning your health coverage is maintained by the Chief of the Recovery Branch, by authority of the Welfare and Institutions Code, Section 14011, and Title 22, California Code of Regulations, Section 50769. All information is mandatory.

Section 14023 of the Welfare and Institutions Code provides that any public assistance recipient who has any other contractual or legal entitlement to any health care service and who willfully refuses to disclose this information by withholding important information regarding other medical entitlement is guilty of a misdemeanor. Medi-Cal is the payor of last resort. Additionally, Section 50175 of Title 22 (CCR) provides for denial or discontinuance of benefits if the recipient does not cooperate in providing health insurance information.